MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

184

69519

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Mardella Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Mardella Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Ethel St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Victoria Unity Brewer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: John Eland Brewer.

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): 1908 Oct. 2nd 1908

8. AGE: Years	Months	Days	If less than one day
39.	0	28	....hrs. ....min.

9. Birthplace: Mardella, Wicomico, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: George Elbert Mayers

13. Birthplace: Mardella Md.

MOTHER — 14. Maiden name: Cora Elizabeth Bailey

15. Birthplace: Mardela Md

16. Informant: John Eland Brewer

Address: Mardella, Md.

17. Burial — Date thereof: Nov. 3-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Mardela Cem.

Location: Mardela Maryland

18. Funeral director: Holloway & Wallace R. Holloway

Address: Salisbury Maryland

19. 11/3 1947. Received by Registrar: Beatrice E. Johnson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31st 1947, at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Accident & Gunshot Wound

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Bullet wound of Brain	sudden
Due to: accidental discharge of rifle.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 10/31/47

Where did injury occur? Mardela (City or town), Wicomico (County), Md. (State)

Injured at home, farm, industry, public place (where?): At home.

Means of injury: Bullet wound Injured at work? no

23. SIGNATURE: Elmer T. Fisher, M.D. or other

Address: Salisbury Md. Date signed: 10/31/47

VS A15 9-47M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. North

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137a

09455

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Somerset

City or town Princess Anne Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 315 Hampton ave
(If rural, give LOCATION)

2.(a) If veteran, name war no ✓

3. (a) FULL NAME Brown Noah

3. (b) Social Security Number 218-20-2486

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	Married

6.(b) Name of husband or wife Lester Brown

6.(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Feb 12, 1888

8. AGE: Years 59 | Months | Days | If less than one day ...hrs. ...min.

9. Birthplace Hamtown Va
(Town, county, and state)

10. Usual occupation Minister

11. Industry or business Same as above

FATHER
12. Name James H Brown
13. Birthplace Hamtown Va.

MOTHER
14. Maiden name Isibella
15. Birthplace Hamtown Va

16. Informant Mrs Lester Brown

Address Princess Anne Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory St. Mary's Oct. 9 1947

Location West Post Office

18. Funeral director James L. Stewart

Address Salisbury Md

19. 10/9 1947 Harriet A. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7- 1947 at 2p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1947, to Oct 7 1947

and that I last saw him alive on Oct 7 1947

Immediate cause of death	DURATION
Hypertension Nephritis	4
Due to	
Due to	
Other conditions ✓	

(Include pregnancy within 3 months of death)

Major findings of operations Nil

Date of op. 10/1/47

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? ✓ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Neal M. D. or other

Address Salisbury Date signed 10/8/47

VS-A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

09456

CERTIFICATE OF DEATH

Reg. Diat. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Worcester County

City or town Pittsville m D

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester County

City or town Pittsville m D R F D #

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Alice E Carey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11 1892

8. AGE: Years	Months	Days	If less than one day
55	5	6	hrs. min.

9. Birthplace Delaware (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name William Pickards

13. Birthplace Delaware

MOTHER 14. Maiden name Eliza Betts (Short)

15. Birthplace Maryland

16. Informant William Lynch

Address Milton Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 20 1947 (month) (day) (year)

Cemetery or crematory Parsons Cemetary

Location Near Pittsville Md

18. Funeral director N B Coleman

Address Milton Del

19. 10/20 1947 H T Barrett Johnson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17th 1947, at 1130 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 17 1947, to Oct 17 1947

and that I last saw her alive on 10-17-47 1947

Immediate cause of death	DURATION
Coronary thrombosis	4 hrs.
Due to	
Due to	
Other conditions Diabetes mellitus	15 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

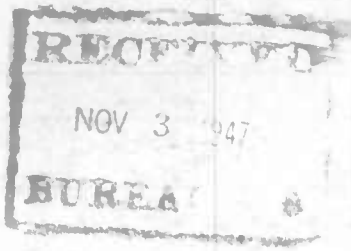
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank A Lewis M D

M. D. or other

Address Pittsville Md Date signed 10-17-47


NOV 3
BUREA

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

09457

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Fruitland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54 years

Hospital, institution, or street address where death occurred: ✓

How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Fruitland

(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME: Leon L. Carey

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single ✓

6.(b) Name of husband or wife ✓

6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.): July 27, 1893

8. AGE: Years 54 | Months 3 | Days 3 | If less than one day: hrs. min.

9. Birthplace: Fruitland, Wicomico, Md. (Town, county, and state)

10. Usual occupation: Lawyer ✓

11. Industry or business ✓

FATHER — 12. Name: John L. Carey

13. Birthplace: Wicomico Co., Md.

MOTHER — 14. Maiden name: Mamie M. Fields

15. Birthplace: Wicomico Co., Md.

16. Informant: Mrs. Mamie M. Carey,

Address: Fruitland, Md.

17. Burial (Burial, cremation, or removal) Which?: Burial — Date thereof: 10/27/47 (month) (day) (year)

Cemetery or crematory: Fruitland Methodist

Location: Fruitland, Md.

18. Funeral director: W. Willis Johnson Co.,

Address: Salisbury, Md.

19. 10/27/47 (Date rec'd by registrar) H. L. Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 25 1947, at 11.50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-47 1947 to 10-25-47 1947

and that I last saw h[illegible] alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage —	
Due to: Hypertension	1-2 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: X Date of: X

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: Lee L. Lowry M.D. (M. D. or other)

Address: Fruitland Md Date signed: 10-25-47

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09458

CERTIFICATE OF DEATH

Reg. Dist. No. 9 3 9

1. PLACE OF DEATH:

County: Prince

City or town: Allen (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Dames Quarter (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Rena Callier

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	married

B.(b) Name of husband or wife: Oliver Callier

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Unknown 1893

8. AGE: Years: 54 Months: Days: If less than one day: ..... hrs. ..... min.

8. Birthplace: Dames Quarter, Somerset Co. Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER — 12. Name: Thos. James

13. Birthplace: Md

MOTHER — 14. Maiden name: Lottie White

15. Birthplace: Md

16. Informant: Oliver Callier

Address: Westover - RD Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-17-47 (month) (day) (year)

Cemetery or crematory: Revell Neck

Location: Revell Neck Md. Somerset Co.

18. Funeral director: William H. James Jr.

Address: Princess Anne Md

19. 10/16/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14th 1947, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 7 1946, to Oct 14th 1947

and that I last saw h ..... alive on ..... 19.....

Immediate cause of death	DURATION
Carcinoma of Bladder	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Chas T. Fisher M.D. (M. D. or other)

Address: Salisbury Md. Date signed: 10/16/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of year of birth shown on FILM No. G 113 NOV 12 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

69459

Reg. Dist. No. 337

1. PLACE OF DEATH:

County: Wicomico

City or town: Nanticoke (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Nanticoke (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Samuel Conway

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	col.	Widower

6.(b) Name of husband or wife: Julia Conway 6.(c) If alive, give age: dead years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1853?

8. AGE: Years	Months	Days	If less than one day
94	9	15	hrs. min.

9. Birthplace: Burgess Store, Northumberland Co. Va.
(Town, county, and state)

10. Usual occupation: Oysterman

11. Industry or business

MOTHER FATHER

12. Name: Filberto Conway

13. Birthplace: Burgess Store, Va.

MOTHER

14. Maiden name: ?

15. Birthplace: ?

16. Informant: Lessie Barclay

Address: Nanticoke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/14/47 (month) (day) (year)

Cemetery or crematory: Nanticoke Col. Cem.

Location: Nanticoke, Md.

18. Funeral director: C. G. Messick

Address: Bivalve, Md.

19. 10/14 1947 (Date rec'd by registrar) R.W. Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 11 1947, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 April 1947 to 11 October 1947 and that I last saw h... alive on 11 October 1947.

Immediate cause of death	DURATION
Mesenteric thrombosis	7 days
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Richard H Saunders M.D. M. D. or other

Address: Nanticoke Md. Date signed: 13 Oct 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore

94a 09460

CERTIFICATE OF DEATH

Reg. Dist. No. 533

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:
P.G. Hospital - Salisbury Md.

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Sharptown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Irving Lee Covington, Irving Lee

3.(b) Social Security Number 221-03-4110

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Radie P. Covington

6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) 4-5-1890

8. AGE: Years	Months	Days	If less than one day
57	6	23	...hrs. ...min.

9. Birthplace Camden, New Jersey
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name Thomas J. Covington

13. Birthplace Sharptown, Maryland

MOTHER 14. Maiden name Margaret E. Selby

15. Birthplace Nr. Sharptown, Maryland

16. Informant Clyde Covington

Address Sharptown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-30-47 (month) (day) (year)

Cemetery or crematory Firemen's Cemetery

Location Sharptown, Maryland

18. Funeral director W. D. Gravenor & Bro

Address Sharptown, Maryland

19. 10/30 (Date rec'd by registrar) 19 47 Harriet J. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 19 47 at 12 30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 19 19 47, to Oct. 28 19 47

and that I last saw h... alive on Oct. 27 19 47

Immediate cause of death	DURATION
Acute Coronary Artery Occlusion	Symptoms 9 days
Due to Arteriosclerosis	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David L. Gilmore M.D. M. D. or other

Address 504 Camden Salisbury Md. Date signed Oct. 29, 1947

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46e

CERTIFICATE OF DEATH

09461

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yr.
Hospital, institution, or street address where death occurred: 308 Hastings st.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 308. Hastings (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George S. Davis

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6. (b) Name of husband or wife: Millie Davis
6. (c) If alive, give age: 70 years
7. Birth date of deceased (mo., day, yr.): Dec. 31 - 1870

8. AGE: Years: 76 Months: 9 Days: 19 If less than one day ... hrs. ... min.

9. Birthplace: Merrillan Wisc. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Mill Work

FATHER
12. Name: Alfred Davis
13. Birthplace: New Hampshire

MOTHER
14. Maiden name: Carrie M. Abbott
15. Birthplace: Unknown

16. Informant: Frank G. Davis
Address: 39 S. Arlington av Balto 23 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 21-47 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Md.

19. 10/21/ 1947 (Date rec'd by registrar) H. L. Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 19th 1947, at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1947, to Oct 14 1947
and that I last saw him alive on October 17 1947

Immediate cause of death	DURATION
Carcinoma of Caecum	8 mon
Due to	
Due to	

Other conditions: Generalized Arteriosclerosis (Include pregnancy within 3 months of death)

Major findings of operations: Abscess of Caecum
Date of op. March 20 1947

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: H A Brule M. D. or other
Address: 304 N Division St Date signed 10.21.47


NOV 3 1947

Dr Gilmore

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

09462

CERTIFICATE OF DEATH

Reg. Dist. No. 383

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? appro. 12 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Worcester

City or town Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war NO

3.(a) FULL NAME Douglas, Bessie

3.(b) Social Security Number

Born Camp La Snow Hill, Md

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	

6.(b) Name of husband or wife Jessie Douglas

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 10 - 1906

8. AGE: Years	Months	Days	If less than one day
42	5	2	..... hrs. ..... min.

9. Birthplace Snow Hill, Worcester, Md (Town, county, and state)

10. Usual occupation Farmwife

11. Industry or business Own Home

FATHER 12. Name William Fisher

13. Birthplace Maryland

MOTHER 14. Maiden name Rosie Hamon

15. Birthplace Maryland

16. Informant Jessie I Douglas

Address Snow Hill, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 14 47 (month) (day) (year)

Cemetery or crematory Woodlawn

Location Pocomoke City, Md

18. Funeral director Clay E Dennis

Address Snow Hill Md

19. 10/16 19 47 Earle E. Johnson Local Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 19 47, at 6 03/4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 10 19 47 to Oct. 11 19 47

and that I last saw her alive on Oct 11 19 47

Immediate cause of death	DURATION
Subarachnoid Hemorrhage	Symptoms 24 hrs.
Due to	
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David J. Gilmore M. D.

M. D. or other

Address 504 Camden Salisbury Md. Date signed Oct. 12, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

69520

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170c

CERTIFICATE OF DEATH

Reg. Dist. No. 339

MV

1. PLACE OF DEATH:
County: Wicomico
City or town: SALISBURY
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Eden Route #1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Dykes, Orville J. H. | **3. (b) Social Security Number:**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Jean M. Dykes
6.(c) If alive, give age: 29 years
7. Birth date of deceased (mo., day, yr.): April 25-1917

8. AGE: Years: 30 | Months: 6 | Days: 5 | If less than one day: hrs. min.

9. Birthplace: Worcester County Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Clayton E. Dykes
13. Birthplace: Worcester Co. Md.
MOTHER 14. Maiden name: Martha E. Coulbourne
15. Birthplace: Wicomico Co. Md.
16. Informant: Mrs. Jean M. Dykes
Address: RD #1. Eden Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 2-1947 (month) (day) (year)
Cemetery or crematory: Zion Cem.
Location: Worcester Co. Near Frankford Md
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland
19. 11/2, 1947 Received by Registrar: Lorrie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/30 1947 at 9.40 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h[im] alive on 19

Immediate cause of death	DURATION
Brain injury	5 days
Co. Fractured Left Femur	5 days.
Due to Fractured Left Tibia	5 days
Fractured Left Patella	5 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Fractured Left Femur
Date of op. 10/25/47
Autopsy results: not
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of injury 10/25/47
Where did injury occur? Meadow Bridge (City or town) Wicomico (County) Md (State)
Injured at home, farm, industry, public place (where?) Highway
Means of injury: Car ran into ditch & turned over Injured at work? no

23. SIGNATURE: J. A. Rademaker M.D.
Deputy Medical Examiner M. D. or other
Address: Salisbury Md Date signed: 10/30/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

09463

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Worchester

City or town Sawn Hill
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rurol, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Greene

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Newborn

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 7, 1947

8. AGE:

Years	Months	Days	If less than one day
			11 hrs. 49 min.

9. Birthplace Salisbury, Wicomico, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name William E. Green
13. Birthplace Cambridge, Mass.

MOTHER
14. Maiden name Alvirta Mae Green
15. Birthplace New York

16. Informant Peninsula Hospital B.B.
Address Salesbury, Md.

17. Cremation Date thereof Oct. 7, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory P. L. H. C.

Location Salisbury, Maryland

18. Funeral director Peninsula General Hospital C.W.
Address Salisbury, Maryland

19. 10/8 19 47 H. L. Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7th 1947, at 9:49 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-6-47 1947, to 10-6-47 1947

and that I last saw h[illegible] alive on 10-6-47 1947

Immediate cause of death	DURATION
Prematurity	
Due to	11 hrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Raymond Robbins M.D.
M. D. or other

Address Salisbury, Md. Date signed 10-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15


RECEIVED
OCT 13 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09464

Reg. Dist. No. 337

1. PLACE OF DEATH:
County: Wicomico
City or town: Tyaskin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Tyaskin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Julia Handy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	col	widowed

6.(b) Name of husband or wife: Carr Handy
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 4, 1877

8. AGE: Years	Months	Days	If less than one day
70	3	1	hrs. min.

9. Birthplace: Tyaskin, Wicomico, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

MOTHER FATHER
12. Name: William Conway
13. Birthplace: Tyaskin, Md.
14. Maiden name: Sally Conway
15. Birthplace: Tyaskin, Md.

16. Informant: Shelley Handy
Address: Tyaskin, Md.

17. Burial — Date thereof: 10/9/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Newtown Cemetery
Location: Tyaskin, Md.

18. Funeral director: C. S. Messick
Address: Bivalve, Md.

19. 10/9 1947 R. N. Walter
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 6 1947, at 11:30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 October 1947 to 6 October 1947 and that I last saw h. alive on 6 October 1947

Immediate cause of death: Cerebral Hemorrhage — DURATION: 5 days.
Due to: Hypertension, Arteriosclerotic — 2 "
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert H. Saunders M.D.
M. D. or other
Address: Mardela Springs, Md. Date signed: Oct 7 47

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

09465

CERTIFICATE OF DEATH

Reg. Dist. No. 353

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Wicomico
City or town: Parsonsburg (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 69 years
Hospital, institution, or street address (Where death occurred): Parsonsburg, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Parsonsburg (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Daniel J. Hastings

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Martha J. Hastings
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): December 7, 1877

8. AGE:

Years	Months	Days	If less than one day
69	10	17	hrs. min.

9. Birthplace: Wicomico Co., Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
12. FATHER Name: Levin W. Hastings
13. FATHER Birthplace: Wicomico Co., Maryland
14. MOTHER Maiden name: Caroline V. Holloway
15. MOTHER Birthplace: Wicomico Co., Maryland
16. Informant: Mrs. M. J. Hastings
Address: Parsonsburg, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/28/47 (month) (day) (year)
Cemetery or crematory: Wicomico Memorial Park
Location: Salisbury, Maryland
18. Funeral director: The Joel T. Johnson Co.
Address: Salisbury, Maryland
19. 10/26, 1947 (Date rec'd by registrar) Everett G. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24, 1947, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1946 to Oct 24 1947 and that I last saw him alive on Oct 24 1947

Immediate cause of death	DURATION
Arteriosclerotic heart disease	
Due to: Arteriosclerosis	
Due to:	
Other conditions: Bronchial Asthma	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Fred L. Gramse M.D. (M. D. or other)
Address: Salisbury, Md. Date signed: 10/24/1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122a

09466

CERTIFICATE OF DEATH

Reg. Dist. No. 939

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days - 4 Hours

Hospital, Institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County Sussex

City or town Seaford

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9 North Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Holt, Mrs. Reba ELIZABETH

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Mr. Elmer Holt

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) SEPT 11, 1899

8. AGE: Years	Months	Days	If less than one day
48	0	26	hrs. min.

9. Birthplace LAUREL, SUSSEX, DELAWARE (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business OWN HOME

FATHER 12. Name J.W. TRUITT

13. Birthplace PARSONBURY, MARYLAND

MOTHER 14. Maiden name SARA C. WHEATLEY

15. Birthplace GALESTOWN, MARYLAND

16. Informant ELMER HOLT

Address SEAFORD, DELAWARE

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof Oct. 9, 1947 (month) (day) (year)

Cemetery or crematory ODD FELLOW'S CEMETERY

Location SEAFORD, DELAWARE

18. Funeral director Medford L Watson Jr.

Address SEAFORD, DELAWARE

19. 10/7 (Date rec'd by registrar) 1947 Harriet L. Johnson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6th 1947 at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1947 to Oct 6 1947 and that I last saw h[illegible] alive on Oct 6 1947

Immediate cause of death	DURATION
Abdominal abscess	
Due to	
Due to	
Other conditions Ventral hernia	

(Include pregnancy within 3 months of death)

Major findings of operation Abdominal abscess Partial obstruction of intestine Op. Oct 6, 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Rufus G. Lowe M.D. M. D. or other

Address Salisbury Md Date signed 10-6-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Rademacher

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 181

09467

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Sharptown
(If outside city or town limits, write RURAL and give nearest town)

Street No. San Domingo
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Hopkins, Lillian

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife Levin Hopkins

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) August 22, 1878

8. AGE: Years 69 | Months 1 | Days 10 | If less than one day ..... hrs. ..... min.

9. Birthplace Wicomico County, Maryland
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER
12. Name Bayard H. Brown
13. Birthplace Wicomico County, Maryland

MOTHER
14. Maiden name Mary A. Sampson
15. Birthplace Dorchester County, Maryland

16. Informant Noah Hopkins

Address Marden Springs, Maryland R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 11, 1947 (month) (day) (year)

Cemetery or crematory San Domingo Cemetery

Location Near Sharptown, Maryland

18. Funeral director J. J. Trampton & Son

Address Eldersburg, Maryland

19. 10/9/47 (Date rec'd by registrar) Maggie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7th 1947, at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19.. and that I last saw him alive on ..... 19.....

Immediate cause of death	DURATION
Burns of face, body & arms	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. .....

Autopsy results Non

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10/2/47

Where did injury occur? Sharptown (City or town) Wicomico (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Kerosene stove exploded injured at work? No

23. SIGNATURE Joe Rademacher MD M. D. or other

Address Salisbury, Md. Date signed 10/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If unknown, state so. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

69521

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: SALISBURY

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 79 years

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland. County: Wicomico

City or town: SALISBURY.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 102 Chestnut Street.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME A. Johnson, Mr. Sidney.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	W	Widower

6.(b) Name of husband or wife: Agnes Bacon Johnson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 8, 1868.

8. AGE: Years 79 Months 9 Days 27 If less than one day ..... hrs. ..... min.

9. Birthplace: Wicomico Co. Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: U.S. Mail Carrier Postal Dept.

FATHER 12. Name: William T. Johnson

FATHER 13. Birthplace: Wicomico Co. Md.

MOTHER 14. Maiden name: Mary Glenn

MOTHER 15. Birthplace: Wicomico Co. Md.

16. Informant: Mrs. B. Johnson

Address: 45 Spencer Ave., Lancaster, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/1/47 (month) (day) (year)

Cemetery or crematory: Parsons

Location: Salisbury, Md.

18. Funeral director: W. Hall Johnson Co.,

Address: Salisbury, Md.

19. 11/1 (Date rec'd by registrar) 19 47 Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 30 19 47 at 5 02 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 23 19 47 to Oct 30 19 47 and that I last saw h... alive on Oct 29 19 47

Immediate cause of death	DURATION
(a) Uraemia	7 hr
Due to (b) Chronic nephritis	2
Due to (c) Chronic myocarditis	2
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Summer M.D. (M. D. or other)

Address: Salisbury Date signed Oct 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-43-15

Onsley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

09468

Reg. Dist. No. 23-3

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worchester

City or town Ocean City

(If outside city or town limits, write RURAL and give nearest town)

Street No. na

(If rural, give LOCATION)

2.(a) If veteran, name war na

3. (a) FULL NAME Jones, Elizabeth

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife John H. Jones

6.(c) If alive, give age yes years

7. Birth date of deceased (mo., day, yr.) Sept 10 — 1899

8. AGE: Years	Months	Days	If less than one day
48	1	8	....hrs. ....min.

9. Birthplace Winston Salem N.C. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Same As above

FATHER 12. Name Unknown

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace Unknown

16. Informant John H. Jones

Address Ocean City md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 20-1947 (month) (day) (year)

Cemetery or crematory Evergreen

Location Berlin Md

18. Funeral director James H. Stewart

Address Salisbury Md

19. Oct 20, 1947 (Date rec'd by registrar) Rachel E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Octobee 17th 1947, at 10 35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 11 1947, to Oct 17 1947

and that I last saw h.e.r alive on Oct 17 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lucy A. Linsley M. D. or other

Address Salisbury Md Date signed 10/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Dr. Embly

09469

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 260

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? One m. + 10 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Somerset
City or town Princess Anne Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jones, Minnie

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	C	✓

6.(b) Name of husband or wife Jones Ernest
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) —1883

8. AGE: Years	Months	Days	If less than one day
64			..... hrs. ..... min.

9. Birthplace Westover Somerset Md., (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name John Miles
13. Birthplace —

MOTHER
14. Maiden name unknown
15. Birthplace —

16. Informant Ernest Jones Princess Anne
Address Mt. Vernon, Md. Posteffice

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 27 1947 (month) (day) (year)
Cemetery or crematory Polks Road Cemetery
Location Mt. Vernon - Pr Anne, Md.

18. Funeral director Charles Dashiell
Address Princess Anne, Md.

19. 10/27 1947 R. F. Johnson M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 1947 at 4 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 9 1944, to Oct 23 1947
and that I last saw h.. alive on Oct 23 1947

Immediate cause of death	DURATION
Intestinal Obstruction	4 days
Due to Abdominal Tumor	
Due to	
Other conditions Ulcer of Leg.	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Frank Matus M.D. M. D. or other
Address Princess Anne Date signed 10/24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH (NEADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Dr. C. Fisher

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

09470

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 years

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 2 days 14 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 301 N. Division St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Mrs. Samuel L. Maddox

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife: Dealie B. Maddox

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Sept. 20, 1870.

8. AGE:

Years	Months	Days	If less than one day
77	0	24	hrs. min.

9. Birthplace: Somerset Co., Md.
(Town, county, and state)

10. Usual occupation: Retired Baker

11. Industry or business:

FATHER
12. Name: Littleton Maddox
13. Birthplace: Somerset Co., Md.

MOTHER
14. Maiden name: Lizzie Long
15. Birthplace: Somerset Co., Md.

16. Informant: Mrs. S. L. Maddox
Address: 301 N. Division St., Salisbury, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 10/16/47
(month) (day) (year)

Cemetery or crematory: Parsons
Location: Salisbury, Md.

18. Funeral director: Dale Hill Johnson Co.
Address: Salisbury, Md.

19. 10/16, 1947 (Date rec'd by registrar) Barnett E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14 1947, at 12 40 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10/1 1947 to 10/14 1947 and that I last saw h— alive on 10/14 1947

Immediate cause of death	DURATION
Chronic myocarditis	2 yrs
C Arterio sclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Chas T. Fisher M.D.
M. D. or other

Address: Salisbury, Md. Date signed: 10/14/47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

State

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

09472

CERTIFICATE OF DEATH

Reg. Dist. No. 323

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Worchester

City or town Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 508 Fifth St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Manuel, Moses

3. (b) Social Security Number 215-26-4600

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Etta Manuel

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) August 15-1884

8. AGE: Years 63 | Months 1 | Days 28 | If less than one day ... hrs. ... min.

9. Birthplace Stockton Worcester Md.
(Town, county, and state)

10. Usual occupation Clerk, Sea Food Market

11. Industry or business

FATHER 12. Name Avin Manuel

13. Birthplace Md.

MOTHER 14. Maiden name Unknown

15. Birthplace "

16. Informant Etta Manuel

Address Pocomoke Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 19-1947 (month) (day) (year)

Cemetery or crematory

Location Stockton Md

18. Funeral director Henry Stevenson

Address Pocomoke City Md.

19. 10/16, 1947 (Date rec'd by registrar) Harriet D. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1947, at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 10 1947 to Oct. 13 1947 and that I last saw him alive on Oct. 13 1947

Immediate cause of death	DURATION
Respiratory failure	
Due to Nephrosclerosis	10 days
Due to Acute cardiac dilitation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Acute degeneration of liver, spleen & kidneys Date of op. 10-14-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert R. Stan M. D. or other

Address Salisbury Date signed 10/13-47

PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13b

09473

Reg. Diat. No. 933

1. PLACE OF DEATH: Wicomico

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7

Hospital, institution, or street address where death occurred: 107 W. Balto. Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 W. Balto. Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Emma McDaniel

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William Thomas McDaniel

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): June 10 1877

8. AGE:

Years	Months	Days	If less than one day
70	4	13	...hrs. ...min.

9. Birthplace: Olivia Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at Home

FATHER

12. Name: Unknown (Price)

13. Birthplace: Somerset Co. Maryland

MOTHER

14. Maiden name: Unknown (Willis)

15. Birthplace: Somerset Co. Md.

16. Informant: Mr. Wm. J. McDaniel

Address: 107 W. Balto. Ave. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Oct. 25-1947 (month) (day) (year)

Cemetery or crematory: Parsons Cem.

Location: Salisbury Maryland

18. Funeral director: Wilson & Walter R. Wilson

Address: Salisbury Md.

19. 10/25/47 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 23rd 1947 at 4:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1947, to Oct 23 1947

and that I last saw h... alive on ... 19...

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 9 mo.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Fred R. Grunow M.D. M. D. or other

Address: Salisbury, Md. Date signed: 10/25/47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09471

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Fruitland md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Six weeks
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Fruitland Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. no
(If rural, give LOCATION) no
2.(a) If veteran, name war

3. (a) FULL NAME Inez Mills

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	A.A.	no

6.(b) Name of husband or wife: no
no 6.(c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.): Jan 10 1947

8. AGE: Years | Months: 8 | Days | If less than one day: hrs. min.

9. Birthplace: Stapleton Ga
(Town, county, and state)

10. Usual occupation: no

11. Industry or business: no

FATHER 12. Name: Bennie Mills

13. Birthplace: Jefferson Co. Ga.

MOTHER 14. Maiden name: Gladys Parker

15. Birthplace: Stapleton, Florida.

16. Informant: Gladys Parker

Address: Fruitland md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 7 1947 (month) (day) (year)

Cemetery or crematory: M.T. Calvery

Location: Fruitland, Md.

18. Funeral director: James F. Stewart

Address: Salisbury Md

19. 10/8 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/7 19 47, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-1-47 19 to 10-6-47 19

and that I last saw h[illegible] alive on 10-6-47 19

Immediate cause of death	DURATION
whooping Cough -	? -
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Lee L Laury M.D.
M. D. or other

Address: Fruitland Date signed: 10-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09474

469

CERTIFICATE OF DEATH

Reg. Dist. No. 11336

1. PLACE OF DEATH:

County Wicomico

City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 years

Hospital, institution, or street address where death occurred:
415 East Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)

Street No. 415 East
(If rural, give LOCATION)

2.(a) If veteran, name war -----

3.(a) FULL NAME Myrtle Anna Niblett

3.(b) Social Security Number 214-10-8440

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Lester Niblett

6.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1900

8. AGE: Years	Months	Days	If less than one day
47	2	8	..... hrs. ..... min.

9. Birthplace Delmar, Delaware
(Town, county, and state)

10. Usual occupation Seamstress

11. Industry or business Pants Factory

FATHER
12. Name Bradbury Vincent
13. Birthplace Greenwood, Delaware

MOTHER
14. Maiden name Clara Hearn
15. Birthplace Delmar, Delaware

16. Informant Lester Niblett

Address 415 East St. Delmar, Delaware

17. Burial (Burial, cremation, removal, Which?) Date thereof Oct. 21, 1947 (month) (day) (year)

Cemetery or crematory Mt. Olive Methodist

Location Delmar, Delaware

18. Funeral director W. S. Morrel Co.

Address Delmar, Delaware

October 20, 1947 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1947, at 5 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 1st 1947, to October 18 1947

and that I last saw her alive on October 1st 1947

Immediate cause of death	DURATION
Cancer of pan- creas	
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. V. Fohler M.D. / M. D. or other

Address Delmar, Del. Date signed 10-20-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

09475

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:
County: Wicomico
City or town: Nanticoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 49 year
Hospital, institution, or street address where death occurred: Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Nanticoke
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: L Ray Nutter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Color	Widowed

6.(b) Name of husband or wife: Annie F Nutter
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 12, 1898

8. AGE: Years	Months	Days	If less than one day
49	0	2	..... hrs. ..... min.

9. Birthplace: Nanticoke Wicomico co. Md
(Town, county, and state)
10. Usual occupation: Labor
11. Industry or business

FATHER
12. Name: William Nutter
13. Birthplace: Wicomico co. Md

MOTHER
14. Maiden name: Henriette Barkley
15. Birthplace: Wicomico co. Md

16. Informant: Mrs Samuel Turner
Address: Nanticoke, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 17-47 (month) (day) (year)
Cemetery or crematory: Nanticoke Cemetery
Location: Nanticoke, Md.

18. Funeral director: Wilson Funeral Home - Leim R. Wilson
Address: Princess Anne Md

19. 10/17 (Date rec'd by registrar) 1947 R. N. Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 17, 1947, at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 April 1947 to 14 October 1947
and that I last saw h... alive on 14 October 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to: Arterio-sclerosis	3
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: Richard H Saunders M.D.
M. D. or other
Address: Nanticoke Md Date signed: 17 Oct 47

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

09476

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Moses Robert Mutter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Emma J. Mutter

6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): June 10th 1892

8. AGE:

Years	Months	Days	If less than one day
56	3	24	..... hrs. ..... min.

9. Birthplace: Nanticoke, Md.
(Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business

FATHER 12. Name: Horace M. Mutter

13. Birthplace: Md.

MOTHER 14. Maiden name: Emma Dutton

15. Birthplace: Md.

16. Informant: Emma Mutter

Address: Salisbury, Md R.D. 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/8/47 (month) (day) (year)

Cemetery or crematory: Nanticoke Cem.

Location: Nanticoke Md.

18. Funeral director: David E. Meseck

Address: Hebron Md.

19. 10/8 (Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4 19 47, at 8:26 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Medical Examiners Report to ..... 19 ..... and that I last saw h ..... alive on ..... 19 .....

	DURATION
Immediate cause of death: Shock	about 1 hr
Due to: Compound fractures both legs	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 10/4/47

Where did injury occur? New Salisbury (City or town) Wicomico (County) Md. (State)

Injured at home, farm, industry, public place (where?): Highway

Means of injury: Struck by Automobile Injured at work? No

23. SIGNATURE: Chas. D. Fraser M.D. Medical Examiner M. D. or other

Address: Salisbury Md. Date signed: 10/4/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 333 69522

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Wicomico County

City or town: Salisbury Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 212 4th Street

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Emery Oldson

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., dsy, yr.): 1894

8. AGE: Years	Months	Days	If less than one day
53			... hrs. ... min.

9. Birthplace: unknown (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: none

FATHER 12. Name: unknown

FATHER 13. Birthplace: unknown

MOTHER 14. Maiden name: unknown

MOTHER 15. Birthplace: unknown

16. Informant: E. A. Purnell

Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 29, 1947 (month) (day) (year)

Cemetery or crematory: Public

Location: Salisbury, Md.

18. Funeral director: Brookes M. Cook

Address: Salisbury Md

19. 10/29 1947 (Date rec'd by registrar) Gracie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 24, 1947, at 5:50 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 22, 1947, to Oct 24, 1947

and that I last saw h... alive on Oct 24, 1947

Immediate cause of death	DURATION
Uremia	
Due to: Glomerulo Nephritis	
Due to: Cardio Vasculo Renal Syndrome	?
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: E. A. Purnell, M. D. (M. D. or other)

Address: 800 W Main St. Date signed 10/25/47

Civil

69523

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Rockawalkin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 78 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Rockawalkin
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Nelson, Md., R.D. 2
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John Clayton Phippin

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Minnie B. Phippin
6.(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): July 7, 1858.

8. AGE: Years: 89 | Months: 3 | Days: 20 | If less than one day: hrs. min.

9. Birthplace: Wicomico Co. Md.
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business: ✓

FATHER
12. Name: Clayton Phippin
13. Birthplace: Sussex Co. Del.

MOTHER
14. Maiden name: Lyd Hastings
15. Birthplace: Sussex Co. Del.

16. Informant: Miss Bessie L. Phippin
Address: Nelson, Md., R.D. 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/30/47 (month) (day) (year)
Cemetery or crematory: Methodist Church
Location: Rockawalkin, Md.

18. Funeral director: T. E. Hill & Johnson Co.,
Address: Salisbury, Md.

19. (Date received by registrar) 10/30, 1947 Bessie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 27, 1947, at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 15-47 to Oct. 26 1947, and that I last saw him alive on Oct. 26 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions: Arterio Sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ✓ Date of op.

Autopsy results: ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ✓ Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ✓ Injured at work?

23. SIGNATURE: William Emrich M. D. or other
Address: Nelson, Md. Date signed: Oct. 29th.

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Purnell M.D.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157e

09477

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico Co.

City or town Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Eden Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war Rural

3.(a) FULL NAME Lonnie Russell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Sept 29. 1947

8. AGE: Years | Months | Days 3 | If less than one day ... hrs. ... min.

9. Birthplace Eden Md. (Town, county, and state) Wic

10. Usual occupation none

11. Industry or business none

FATHER 12. Name Donald Russell

FATHER 13. Birthplace Balto. Md.

MOTHER 14. Maiden name Anne Martin

MOTHER 15. Birthplace Eden Md.

16. Informant Donald Russell

Address Eden Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 6, 1947 (month) (day) (year)

Cemetery or crematory Green Acres Mem. Park

Location Salisbury Md

18. Funeral director Dashiell W. Guest

Address Salisbury Md.

19. 10/6/47 (Date rec'd by registrar) Margaret L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 19 47, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 29 19 47, to Oct 2 19 47 and that I last saw h... alive on Oct 2 19 47

	DURATION
Immediate cause of death Asphyxiation	
Due to Congenital heart Disease (Bi-cuspidal Ventricle & Patent foramen ovale)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None (EAP)

Date of op...

Autopsy results Unilocular Ventricle; Patent Foramen Ovale

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE E. Purnell, M.D. M. D. or other

Address 800 W. Main St Salisbury Md Date signed 10/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46b

CERTIFICATE OF DEATH

09478

Reg. Dist. No. 933

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: 116 West Main St. (If outside city or town limits, write RURAL and give nearest town)
Street No.: Salisbury, Md. (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: James L. Sadaus

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bessie J. Sadaus
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): March 13, 1880.

8. AGE: Years: 68 | Months: 6 | Days: 14 | If less than one day: ...hrs. ...min.

9. Birthplace: Wicomico County, Md. (Town, county, and state)
10. Usual occupation: Mechanical Operator
11. Industry or business: ✓
12. Name of father: Peter Sadaus
13. Birthplace of father: Greece
14. Maiden name of mother: Helen Cocalis
15. Birthplace of mother: Greece
16. Informant: Mrs. Bessie J. Sadaus
Address: 116 West Main St., Salisbury, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/9/47 (month) (day) (year)
Cemetery or crematory: Wicomico Memorial Park,
Location: Salisbury, Md.
18. Funeral director: De Vilbiss Johnson Co.
Address: Salisbury, Md.
19. 10/9/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7, 1947, at 2 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1947, to Oct 7, 1947
and that I last saw him alive on Oct 7, 1947

Immediate cause of death	DURATION
Carcinoma of Stomach	1 week
Due to: —	
Due to: —	
Other conditions: Metastases to Liver	
Pneumonia (Include pregnancy within 3 months of death)	2 days

Major findings of operations: Above confirmed
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Howard R Mann M. D. or other
Address: Salisbury Md Date signed: 10/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09479

932

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: R.D. # 4
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. # 4
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edith Mae Shockley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: James S. Shockley
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): March 18 1887

8. AGE: Years: 60 Months: 7 Days: 1 If less than one day: hrs. min.

9. Birthplace: Damascus Md (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business: at Home

FATHER
12. Name: J. Wesley Webster
13. Birthplace: Damascus Md

MOTHER
14. Maiden name: Martha Young
15. Birthplace: Damascus Md

16. Informant: Mrs. Ada Gladden
Address: RD # 4 Salisbury Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof 10-23-47 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md

18. Funeral director: Wm. A. Wilson & Wilson R. Wallace
Address: Salisbury Md.

19. 10/23/47 (Date rec'd by registrar) Margaret E. Dalton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 19 47 at 8-30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1947 to 10/19 1947 and that I last saw him alive on 10/17 1947

Immediate cause of death	DURATION
Arteriosclerosis & Myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F. D. Pearce M.D. M. D. or other
Address: Salisbury Md. Date signed: 10/24/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09480

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:

County: Wicomico

City or town: Tyaskin (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Tyaskin (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: Spanish-American

3. (a) FULL NAME: Harry Gordon Stewart

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Lillian Stewart

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): May 30, 1874

8. AGE: Years	Months	Days	If less than one day
73	4	20	..... hrs. ..... min.

9. Birthplace: Wicksville — Ohio (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER

12. Name: George G. Stewart

13. Birthplace: Unknown

MOTHER

14. Maiden name: Emma Bennix

15. Birthplace: Unknown

16. Informant: Lillian Stewart

Address: Tyaskin, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/24/47 (month) (day) (year)

Cemetery or crematory: Arlington Cemetery

Location: Arlington, Va.

18. Funeral director: C. F. Messick

Address: Bivalve, Md.

19. 10/23 19 47 (Date rec'd by registrar) R. W. Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 21 1947 at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 Oct. 1947 to 21 Oct 1947 and that I last saw him alive on 21 October 1947

Immediate cause of death	DURATION
Massive Cerebral Hemorrhage	15 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Richard H. Saunders M.D.

authorized by L. A. Podewitz Jr. Phys

Address: Crisfield, Md. Date signed: 24 Oct 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and exactly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

48 G

69524

CERTIFICATE OF DEATH

Reg. Dist. No. 3 3 3

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 15 years

Hospital, institution, or street address where death occurred: 503 Moore St

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland, County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 503 Moore St (If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME Anna Almeta Stevenson

3. (b) Social Security Number

4. Sex Female

5. Color or race A A

6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Brodgie Stevenson

6.(c) If alive, give age Don't know years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1910

8. AGE: Years 37 Months 9 Days 14 If less than one day ...hrs. ...min.

9. Birthplace Dames Quarter, Somerset Co. Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Same

FATHER 12. Name George T. White

13. Birthplace Dames Quarter Maryland

MOTHER 14. Maiden name Lillie Fields

15. Birthplace Dames Quarter, Maryland

16. Informant Garrison White

Address 503 Moore St, Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-29-47 (month) (day) (year)

Cemetery or crematory Dames Quarter,

Location Dames Quarter, Maryland

18. Funeral director James F. Stewart

Address 402 E. Church St, Salisbury Md.

19. 10/29, 1947 (Date rec'd by registrar) Harold E. Johnson Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1947 at 2:30 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1946, to Oct 21 1947 and that I last saw her alive on Oct 21 1947

Immediate cause of death Recurrent CA of uterus

DURATION

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings at operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE William D. Gray Intn M. D. or other

Address Salisbury Md Date signed 10/28/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

09481

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Willard R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Willards R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Henry Von Lienen.

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Catherine Von Lienen

6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.): Jan. 7, 1900

8. AGE: Years 47 | Months 8 | Days 29 | If less than one day: hrs. min.

9. Birthplace: WESTERMUNDE, GERMANY (Town, county, and state)

10. Usual occupation: DECORATOR.

11. Industry or business

FATHER 12. Name: PETER N. VON LIENEN

13. Birthplace: GERMANY.

MOTHER 14. Maiden name: REBECCA BUSCH

15. Birthplace: GERMANY

16. Informant: Mrs. G. H. VON LIENEN

Address: WILLARDS MD. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/10/47 (month) (day) (year)

Cemetery or crematory: Mt. Pleasant

Location: Willards R.F.D.

18. Funeral director: Herman A. Bunting

Address: Berlin Md

19. (Date rec'd by registrar) 10/10, 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 Oct 19 47, at 7 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 Oct 47 19 , to 6 Oct 19 47

and that I last saw h.(m) alive on 6 Oct 47 19

Immediate cause of death	DURATION
acute Coronary Thrombosis	
Due to	20 min.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Herman A. Robbins M. D. or other

Address: Bay St. Berlin, Md. Date signed 8 Oct 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

121

09482

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 hrs.
Hospital, institution, or street address where death occurred:
P.B. Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1309 Bell Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War # 2

3.(a) FULL NAME: Webster Mr. William

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Dorothy J. Rice

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 2, 1925

8. AGE: Years: 22 Months: 4 Days: 2 If less than one day: ..... hrs. ..... min.

9. Birthplace: Hebron Wicomico, Md.
(Town, county, and state)

10. Usual occupation: Cashier

11. Industry or business: General Baking Co.

FATHER
12. Name: Eleanor Webster
13. Birthplace: Deal Island Md.

MOTHER
14. Maiden name: Della Ford
15. Birthplace: Oriole Md.

16. Informant: Mrs. Eleanor Webster
Address: Hebron Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 10/7/47 (month) (day) (year)
Cemetery or crematory: Hebron Cemetery
Location: Hebron Md.

18. Funeral director: David K. Messick
Address: Hebron, Md.

19. 10/7/47 (Date rec'd by registrar) 19.47 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4, 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-4 1947 to 10-4- 1947 and that I last saw h.i.m. alive on 10-4-47 19.....

Immediate cause of death	DURATION
Pulmonary embolism	
Due to: Intra mural clot of uterus	
Due to:	
Other conditions: Acute appendicitis Myometritis Abdomitis (Include pregnancy within 3 months of death)	

Major findings of operations:
Date of op. .....

Autopsy results: Pulmonary embolism

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Salisbury Md. Date signed 10-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

09525

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164C

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Something over an hour
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? Often an hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Worcester
City or town Pocomoke City Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 410 Market
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles Thomas West

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife Mary E. West
6.(c) If alive, give age 67 years
7. Birth date of deceased (mo., day, yr.) Dec 9th 1881

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
66	8	10		

9. Birthplace Pocomoke City - Worcester Co Md (Town, county, and state)
10. Usual occupation Retired
11. Industry or business Barrel Manufacturer
FATHER 12. Name Matthew Thomas West
13. Birthplace Delaware
MOTHER 14. Maiden name Mary Virginia Ellis
15. Birthplace Maryland
16. Informant Lilly Johnson (Sister)
Address Newport Va
17. (Burial, cremation, or removal. Which?) Date thereof Nov 2-47 (month) (day) (year)
Cemetery or crematory Burial
Location Nelson Cemetery - Mt Calvary
18. Funeral director Henry H. Watson
Address Pocomoke City Md
19. 10/31 (Date rec'd by registrar) 19 47 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION 50

20. DATE OF DEATH Oct 29th 19 47, at 109 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw him alive on Oct 27th 19 47
Immediate cause of death Suicide - Firearm — DURATION: 4 hours 1 min
Due to
Due to Confirmed Physical Condition and Mental Depression — 2 1/2 yrs
Other conditions Head Injuries received in auto accident (Include pregnancy within 3 months of death) — 4 yrs
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide Date of 10/29/47
Where did injury occur Pocomoke City (City or town) Worcester (County) Md (State)
Injured at home, farm, industry, public place (where?) Home Injured at work? No
Means of injury Firearm - Pistol

23. SIGNATURE H. E. Carlson M.D. M. D. or other
Address Pocomoke City Md Date signed

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09526

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
304 Light St.
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 304 Light St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Nannie Price White

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: R. B. White

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): July 29, 1874.

8. AGE: Years: 73 Months: 3 Days: 1 If less than one day: hrs. min.

9. Birthplace: Allen, Wicomico (Town, county, and state) Md.

10. Usual occupation: At Home

11. Industry or business: ✓

FATHER
12. Name: Levin B. Price
13. Birthplace: Wicomico Co. Md.

MOTHER
14. Maiden name: Mary J. Turner
15. Birthplace: Wicomico Co. Md.

16. Informant: Mr. R. B. White
Address: 304 Light St., Salisbury, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: 11/4/47 (month) (day) (year)
Cemetery or crematory: Methodist Church
Location: Allen, Wicomico, Md.

18. Funeral director: Re. Neil & Shaw Co.
Address: Salisbury, Md.

19. 11/2, 1947 (Date rec'd by registrar) Maggie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 30, 1947, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/24/47 to October 30 1947 and that I last saw h[illegible] alive on October 30 1947

Immediate cause of death	DURATION
Hemorrhage	
Due to: Cancer of Rectum	
Due to:	
Other conditions: Hypertrophied Prostate. Hypertension. (include pregnancy within 3 months of death)	

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Carrie I. Hearn M. D. or other
Address: 203 W. Main St. Date signed: 10/2/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

158

09483

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Wooters

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 18-1947

8. AGE: Years | Months | Days | If less than one day: 9 hrs. 5 min.

9. Birthplace: Salisbury, Wicomico, Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Wooters, Jennings Lee

FATHER — 13. Birthplace: Bethel, Delaware

MOTHER — 14. Maiden name: Slatchers, Blanche Alice

MOTHER — 15. Birthplace: Laurel, Delaware

16. Informant: Peninsula General Hospital Rec.

Address: Salisbury, Maryland.

17. ✓ (Burial, cremation, or removal. Which?) Date thereof: Oct. 20. 1947 (month) (day) (year)

Cemetery or crematory: Peninsula General Hospital

Location: Salisbury, Maryland.

18. Funeral director: Peninsula General Hospital

Address: Salisbury, Maryland

19. 10/20, 1947 (Date rec'd by registrar) Carrie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 18- 1947, at 7:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 18 1947, to Oct. 18 1947 and that I last saw her alive on Oct. 18 1947

Immediate cause of death	DURATION
Respiratory failure	9 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: No positive findings

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Williams M.D. M. D. or other

Address: Laurel, Del. Date signed: Oct. 20, '47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

48 E

09484

CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH:

County Wicomico

City or town Mardela Springs - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred:

Mardela - Sharptown Road

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Mardela Springs - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Mardela - Sharptown Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Alice V. Wright

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Harry F. Wright

6.(c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) December 5, 1913

8. AGE: Years	Months	Days	If less than one day
33	10	18	hrs. min.

9. Birthplace Galestown, Dorchester County, Maryland

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER 12. Name Charles Doran

13. Birthplace Glassboro, New Jersey

MOTHER 14. Maiden name Bessie Hardy

15. Birthplace Sussex County, Delaware

16. Informant Harry F. Wright

Address Mardela Springs, Maryland, R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 25, 1947 (month) (day) (year)

Cemetery or crematory Hill Crest Cemetery

Location Federalsburg, Maryland

16. Funeral director J. J. Frampton and Son

Address Federalsburg, Maryland

19. 10/25/47 (Date rec'd by registrar) 19 W. H. Robertson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 1947, at 12:50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1st 1947, to October 22 1947

and that I last saw h alive on October 21st 1947

Immediate cause of death	DURATION
Carcinoma of Uterus	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William Emrich M. D. or other

Address Hebron, Md. Date signed Oct 23 1947

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. C. Fisher

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

732

09485

CERTIFICATE OF DEATH

Reg. Diat. No. 733

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 42 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Jesterville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Knight, Andrew

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	Widower

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 31, 1893

8. AGE: Years	Months	Days	If less than one day
54	9	14	..... hrs. ..... min.

9. Birthplace: Jesterville, Wicomico, Md.
(Town, county, and state)

10. Usual occupation: Oysterman

11. Industry or business

FATHER — 12. Name: Allen Wright

13. Birthplace: Jesterville, Md.

MOTHER — 14. Maiden name: Ella Mollock

15. Birthplace: Cambridge, Md.

16. Informant: Wilson Wright

Address: Jesterville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/19/47 (month) (day) (year)

Cemetery or crematory: Jesterville Cemetery

Location: Jesterville, Md.

18. Funeral director: C. G. Messick

Address: Bivalve, Md.

19. 10/17/47 (Date rec'd by Registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 15 1947, at 11 25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/3 1947 to 10/15 1947 and that I last saw him alive on 10/15 1947.

Immediate cause of death	DURATION
Pneumonia Anaemia	6 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Chas. T. Fisher, M.D. M. D. or other

Address: Salisbury, Md. Date signed: 10/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45